Australian
Private Hospitals
Association

MBS Review: Report from the Neurology/Neurosurgery Clinical Committee 2018

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Introduction

The Australian Private Hospitals Association (APHA) is appreciative of the opportunity to make a submission to the Medicare Benefits Schedule (MBS) Review in response to the recommendations in the *Draft report from the Neurosurgery and Neurology Clinical Committee (2018).*

In this response, the APHA has focused on issues that could arise for private hospitals if these recommendations were adopted. Some of these issues lie outside the scope of the terms of reference for the MBS Review, for example they pertain to potential implications for the regulations governing private health insurance.

The Private Health Insurance (Benefit Requirements) Rules 2011 (Compilation No. 52, as of 1 November 2018: "the Rules") make detailed reference to relevant MBS items, and it is therefore essential to consider whether recommendations from the MBS Review will give rise to the need for changes to private health insurance regulation.

The issues in this submission are raised with the intention of informing implementation of the proposed recommendations should they be adopted by the Australian Government.

The APHA advocates there should be sufficient time allocated by the Department of Health for the implementation of the flow-on changes when changes are made to the MBS, such as the Rules and the National Procedure Banding Committee processes, especially when there are changes to a large number of MBS items simultaneously.

In making these comments, APHA remains fully supportive of the objectives of the MBS Review and recommendations intended to promote sound, evidence-based clinical practice.

General feedback

Standardised national referral form

The clinical committee suggested the development of a standardised national referral form under recommendations 1, 3 and 4 to be able to refer treatment for items 11000, 11012, 11015, 11018, 11021, 11024 and 11027.

The APHA would value the opportunity to provide input into the development of these standardised referral forms to ensure they will be workable and practical also in the private sector.

The APHA also requests to be added to the stakeholder list of the review of such forms in 2-3 years' time.

Incorporating stereotaxy and cranioplasty into other neurosurgery items

The clinical committee has recommended adding stereotaxy (currently item 40803) to 28 neurosurgical items (under recommendations 11, 12, 14, 15, 16, 17, 18, 19, 20 and 22). Similarly, it has recommended adding cranioplasty (currently item 40600) to nine neurosurgical items (under recommendations 12, 15, 16 and 17). Several of the items are recommended to incorporate both stereotaxy and cranioplasty.

Including stereotaxy and cranioplasty into other items as a matter of course and restricting the ability to co-claim those items going forward is effectively bundling these services, which represents a considerable funding risk for private hospitals.

The APHA respects the clinical committee has made these recommendations to better reflect the clinical service provided and promote best clinical practice, however, these recommendations will create cost pressures in the private sector making them difficult for private hospitals to implement.

Including stereotaxy and/or cranioplasty into an existing item will mean theatre costs associated with each of these items will be higher than the current items. Whilst the MBS Review clinical committee is recognising this though recommending higher schedule fees for these items according to the multiple service rules, they have no scope to influence benefits paid to private hospitals by private health insurers.

The problem the industry as a whole will face is existing neurosurgery items are already classified by the National Procedure Banding Committee. The NPBS is an important reference point for hospitals and health insurers when negotiating contracts. The neurosurgical items recommended to include stereotaxy and/or cranioplasty currently range from a theatre band 4 to band 11 in the National Procedure Banding Schedule (NPBS). Cranioplasty on its own (item 40600) is currently allocated a theatre band 5, and stereotaxy (item 40803) is a theatre band 6. At the very least the industry will require time for parties negotiate an acceptable solution.

It is the view of the APHA that if the recommendations listed above are accepted by the Australian Government, it should be deferred to allow the industry adequate lead time to negotiate appropriate theatre charges.

New items

All new items from the recommendations should be added to the Rules where appropriate if adopted by the Australian Government. The new items from the recommendations are;

- The new item under recommendation 26

  Whilst there is no direct comparator item for the proposed item for stereotactic planning and delivery, the clinical committee suggests a schedule fee which is a combination of items 40803 and 15600. These items are currently classified in the Rules as Type A, Advanced surgical patient.

  The new item should also be classified as Type A, Advanced surgical patient.

- The new item under recommendation 27

  Whilst there is no direct comparator item for the proposed item for awake craniotomy, the clinical committee suggests a schedule fee similar to item 39712, which is classified as Type A, Advanced surgical patient in the Rules.

  The new item should also be classified as Type A, Advanced surgical patient.

- The two new items under recommendation 28

  Whilst the new items under this recommendation have no listed comparator items, botox items are usually classified as Type C, Category 3, Table T11, and these new items could be added there as well if appropriate.

- The two new items under recommendation 29

  Recommendation 29 splits one existing item into three new items. The existing item 39333 is currently classified in the Rules as Type A, Surgical patient. All three of the items should also be classified as Type A, Surgical patient.

Private hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

According to the most recent data available, the private hospital sector treats:

- 4.4 million separations a year.

In 2016–17, it delivered:

- More than a third of chemotherapy
- 60% of all surgery
- 79% of rehabilitation
- 73% of eye procedures
- Almost half of all heart procedures
- 73% of procedures on the brain, spine and nerves.

Australian private hospitals by numbers:

- Half (49%) of Australian hospitals are private
- 657 private hospitals made up of:
    - 300 overnight hospitals
    - 357 day hospitals
- 34,339 beds and chairs
    - 31,029 in overnight hospitals
    - 3,310 in day surgeries
- 69,299 full-time equivalent staff (AIHW 2018, ABS 2018).

The Australian Private Hospitals Association

The APHA is the peak industry body representing the private hospital and day surgery sector. About 70% of overnight hospitals and half of all day surgeries in Australia are APHA members.